

State Innovation Model









DRIVER DIAGRAM

The Iowa SIM Vision:

Transforming Health Care to Improve the Health of Iowans

AIMS

Improve Population Health

 Focus: Diabetes, Obesity, Tobacco use, OB, HAI, Med Safety, SDH

Goals: by 2018

Improve the health of lowans in three areas:

Tobacco: Increase quit attempt

rate by 5.1%

Obesity: Decrease prevalence

rate by 2.9%

Diabetes: Increase A1C test rate

by 4.1%

Reduce the rate of preventable readmissions by 20% in the Medicaid and Wellmark population

Reduce the rate of preventable ED visits by 20% in the Medicaid and Wellmark population

Increase participation in Value Based Purchasing in Iowa, by evidence of 50% of Medicaid, Wellmark, and Medicare payments linked to VBP contracts Transform Healthcare

Focus: Preventable Utilization (ED visits and Inpatient admissions)

Primary Driver

Plan to Improve Population Health

Care Coordination

Community-Based Performance Improvement

Value Based Purchasing (VBP)

Promote Sustainability

 Focus: Providers participating in value-based purchasing and Financial Impacts to healthcare system/Iowans

Secondary Drivers

Assess I ocal and state environment to identify population health needs

Develop and deploy interventions, including statewide strategies

Establish and monitor key population metrics

Execute integrated community based strategies

Inform providers for better care coordination

Execute care coordination models

Optimize use of Health Information Technology (HIT)

Engage leadership & receive leadership Commitment

Develop & implement quality improvement strategies

Conduct rapid cycle evaluation of performance data to stakeholders

Align payers invalue reimbursement and Quality strategies

Implement VBP into the new Managed Care system in Medicaid

Ongoing Evaluation









Categorization of Population Health Activities

Bucket #1: Traditional Clinical Approaches Bucket #2: Innovative Patient-Centered Care

Bucket #3: Community -Wide Health







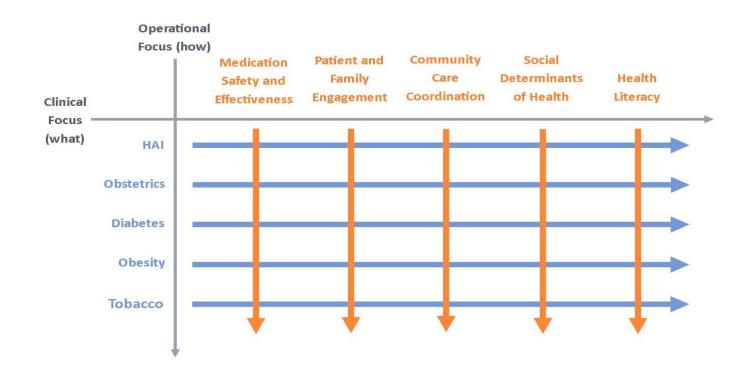
Source: John Auerbach, CDC



















Plan to Improve Population Health

Statewide Strategy Plans

http://idph.iowa.gov/SIM

Written Plan to Improve
 Population Health by January,
 2019: Tobacco, Diabetes, and
 Obesity



Overview Of Healthy Iowans

- Healthy lowans sets the agenda for solving priority health issues facing lowans
- The plan is the outcome of a statewide needs assessment involving public and private partners as well as individuals
- Since the 1990s, Healthy Iowans has included a set of measurable goals with objectives/action steps
- IDPH coordinates ongoing technical assistance, tracking yearly progress, and making revisions









Healthy Iowans Methodology

Local Community Priorities

Data Source: Analysis of local CHNA&HIPs.

Healthy Iowans Recommendations

Data Source: Analysis of stakeholder input.

Burden on Iowans: Is Iowa in bottom 20 states nationally?

Data Source: America's Health Rankings, other secondary data sources.

Health Inequity: Are certain populations disproportionately affected?

Data Source: IDPH data, Iowa Health Profile, secondary data sources.

Gap Analysis: Is there evidence for other issues not already identified?

Data Source: IDPH data, Iowa Health Profile, H.P. 2020, Secondary data

Result: Combine information into State Health Assessment









SIM Plan To Improve Population Health

Focus Areas: Diabetes, Tobacco, and Obesity

- 1. Assessment
- 2. Existing Population Health Efforts
- 3. Roadmap to Improve Population Health









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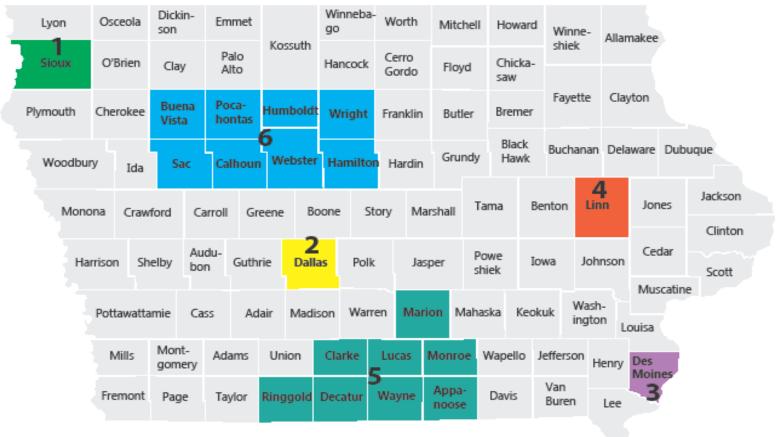
Ongoing Evaluation







State Innovation Model Community Care Coalition Initiative Grantees





http://idph.iowa.gov/Portals/1/userfiles/38/Compiled%20program%20fact%20sheets.pdf

Community Care Coalition (C3) Initiative

Community Care Coalitions:

Consist of a broad group of community partners including health, human services, education, aging, city planners, residents, among others.

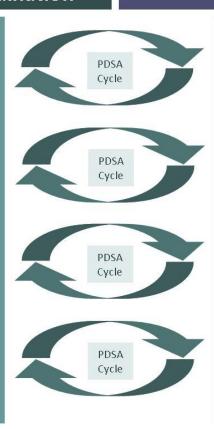
Are guided by a Steering Committee consisting of a small group consisting of hospitals, health providers, public health, human service organizations, etc.

Build and participate in referral processes, participate in process improvement, promote C3 interventions, and educate on the benefits of community-based strategies to support healthy behaviors.

Community Care Coordination

Implementing Interventions from SIM Statewide Strategy Plans

Referrals will be received, barriers identified, may be provided Social Determinants of Health referrals to resources



DIABETES

Community-identified interventions from SIM Diabetes Statewide Strategy Plan and/or local CHNA & HIP

TOBACCO

Community-identified interventions from SIM Tobacco Statewide Strategy Plan and/or local CHNA & HIP

OBESITY

Community-identified interventions from SIM Obesity Statewide Strategy Plan and/or local CHNA & HIP

CHNA & HIP PRIORITY AREA
Community-identified interventions
from local CHNA & HIP and could include obstetrics, healthcare-associated
infections, etc.

Population-based,
Community-applied
policy, systems, and
environmental change
initiatives included in
statewide strategy plans
to support healthy
behaviors and promote
sustainability for longterm change.

Social Determinants of Health

<u>Definition:</u> Conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- Economic Stability
- Education
- Health and Healthcare
- Neighborhood and Built Environment
- Social and Community Context

Source: Healthy People 2020

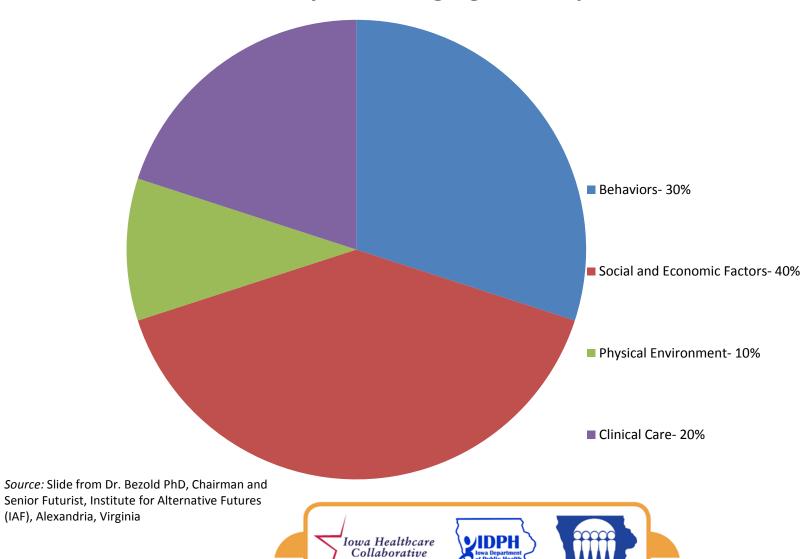








Why is Leveraging SDH Important?



Community Care Coalition (C3) Diabetes Example

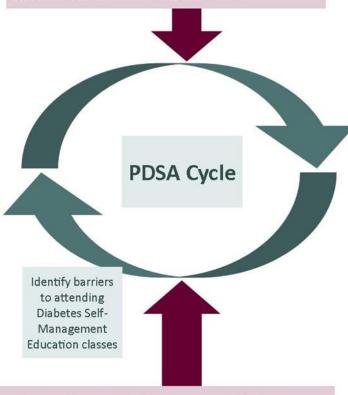
Example of a community-selected intervention from the SIM Diabetes Statewide Strategy Plan

Community Care Coordination

Social Determinants of Health

Referrals will be made; barriers identified and may include lack of access to prescriptions or healthy foods; and resources and referrals may be provided.

Implement process changes based on data analysis. For example, modifications could be made to a referral system to diabetes self-management education program; and/or change the location of the diabetes self-management education course to a community location more accessible to families of low income.



Data will continually be collected by C3 applicant, coalition partners, and IHC to implement community-based performance improvement strategies. Data may include:

- * # of referrals
- * referral sources
- * SWAN data

- * Pharmacy data
- * NQF measures to include HgbA1C
- * VIS data

Implementing Interventions from SIM Statewide Strategy Plans

DIABETES

Community-identified interventions from SIM Diabetes Statewide Strategy Plan

Incorporate standardized glucose testing at annual physical appointments.

Identify barriers within primary care offices to address diabetes screening with patients.

Equip providers to recognize and address social determinants of health. Encourage patient and provider discussions to identify social determinants of health and patient needs impacting care.

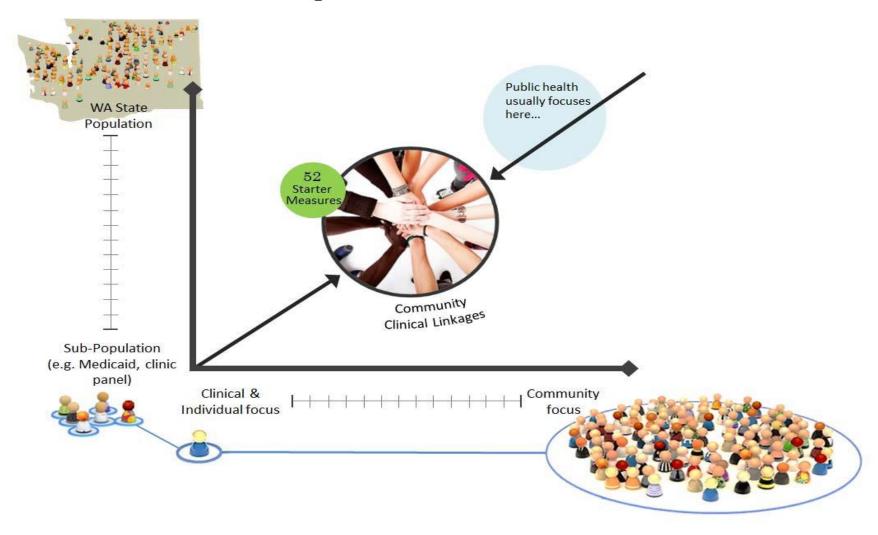
Incorporate referrals to community-based services to assist in addressing barriers to care.

Educate providers and consumers about the purpose and locations of diabetes self-management education and training offerings. Increase provider referral of diagnosed patients to diabetes self-management education and training.

Population-based, Community-applied policy, systems, and environmental change initiatives included in statewide strategy plans to support healthy behaviors and promote sustainability for long-term change. Leverage the work of other concurrent efforts (Healthiest State Initiative, Healthy lowans plan, Wellmark Blue Zones, etc.) to support local access to healthy foods and built environments to promote active lifestyles.

Specific examples include: improving access to healthy foods at food pantries and food banks; educate on benefits of walkable communities; embed permanent payment structure for diabetes self-management education.

Population Health



Graphic courtesy of Healthier Washington



CDC 6/18 Initiative

http://www.cdc.gov/sixeighteen/







